

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Dates of survey: 06/04/14 through 06/05/14</p> <p>Facility number: 004975</p> <p>Complaint number: IN00148646 Unsubstantiated; lack of sufficient evidence</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Saint Catherine Regional Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: cloughlin 06/13/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE